AN ACT

ENTITLED, An Act to establish criteria for the use of utilization review by health carriers, utilization review organizations, and other contracted entities.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. Terms used in this Act mean:

(1) "Adverse determination," a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated;

(2) "Ambulatory review," utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management," a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(4) "Certification," a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(7) "Concurrent review," utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefits" or "benefits," those health care services to which a covered person is entitled under the terms of a health benefit plan;

(9) "Covered person," a policyholder, subscriber, enrollee, or other individual participating in

a health benefit plan;

(10) "Discharge planning," the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Facility," an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings;

(12) "Health benefit plan," a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(13) "Health care professional," a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law;

(14) "Health care provider" or "provider," a health care professional or a facility;

(15) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(15A) "Health carrier," an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services;

(16) "Managed care contractor," a person who establishes, operates, or maintains a network of participating providers; or contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing

coverage for health care services to operate a managed care plan;

(17) "Managed care entity," a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor that operates a managed care plan;

(18) "Managed care plan," a plan operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through any of the following:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; or

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(19) "Necessary information," includes the results of any face-to-face clinical evaluation or second opinion that may be required;

(20) "Network," the group of participating providers providing services to a health carrier;

(21) "Participating provider," a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the health carrier;

(22) "Prospective review," utilization review conducted prior to an admission or a course of treatment;

(23) "Retrospective review," utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(24) "Second opinion," an opportunity or requirement to obtain a clinical evaluation by a

provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(25) "Utilization review," an activity as defined in subdivisions 58-17-91(4) and 58-18-64(4); and

(26) "Utilization review organization," an entity that conducts utilization review.

Section 2. This Act applies to any health carrier that provides or performs utilization review services. The requirements of this Act also apply to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf.

Section 3. A health carrier is responsible for monitoring all utilization review activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of this Act and applicable rules are met. The health carrier shall also ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

Section 4. If a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by this Act or applicable rules, the director shall hold the health carrier responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of this Act and applicable rules are met.

Section 5. A health carrier that conducts utilization review shall implement a written utilization review program that describes all review activities, both delegated and nondelegated, for covered services provided. The program document shall describe the following:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services;

(2) Data sources and clinical review criteria used in decision-making;

(3) The process for conducting appeals of adverse determinations;

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions;

(5) Data collection processes and analytical methods used in assessing utilization of health care services;

(6) Provisions for assuring confidentiality of clinical and proprietary information;

(7) The organizational structure that periodically assesses utilization review activities and reports to the health carrier's governing body; and

(8) The staff position functionally responsible for day-to-day program management.

A health carrier shall prepare an annual summary report of its utilization review program activities and file the report, if requested, with the director and the secretary of the Department of Health.

Section 6. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies including the Division of Insurance and the Department of Health.

Section 7. Qualified licensed health care professionals shall administer the utilization review program and oversee review decisions. Any adverse determination shall be evaluated by an appropriately licensed and clinically qualified health care provider.

Section 8. A health carrier shall issue utilization review decisions in a timely manner pursuant to the requirements of this Act. A health carrier shall obtain all information required to make a utilization review decision, including pertinent clinical information. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

Section 9. A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.

Section 10. A health carrier's data system shall be sufficient to support utilization review program

activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

Section 11. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the utilization review organization program by the health carrier; and

(3) A process by which the health carrier evaluates the performance of the utilization review organization.

Section 12. A health carrier shall coordinate the utilization review program with other medical management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

Section 13. A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

Section 14. When conducting utilization review, the health carrier shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of services.

Section 15. Compensation to persons providing utilization review services for a health carrier may not contain incentives, direct or indirect, for these persons to make inappropriate review decisions. Compensation to any such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Section 16. A health carrier shall maintain written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its

decisions.

Section 17. For initial determinations, a health carrier shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination:

(1) In the case of a determination to certify an admission, procedure, or service, the health carrier shall notify the provider rendering the service by telephone within twenty-four hours of making the initial certification; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within two working days of making the initial certification.

(2) In the case of an adverse determination, the health carrier shall notify the provider rendering the service by telephone within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one working day of making the adverse determination.

Section 18. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the health carrier shall notify by telephone the provider rendering the service within one working day of making the certification; and the health carrier shall provide written or electronic confirmation to the covered person and the provider within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

(2) In the case of an adverse determination, the health carrier shall notify by telephone the provider rendering the service within twenty-four hours of making the adverse

determination; and the health carrier shall provide written or electronic notification to the covered person and the provider within one working day of the telephone notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

Section 19. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information:

(1) In the case of a certification, the health carrier may notify in writing the covered person and the provider rendering the service.

(2) In the case of an adverse determination, the health carrier shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

Section 20. Any written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal, grievance, or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale used to make the determination. A health carrier shall provide the clinical rationale in writing for an adverse determination to any party who received notice of the adverse determination and who follows the procedures for a request. The clinical rationale shall contain sufficient specificity to allow the covered person to understand the basis of the adverse determination.

Section 21. A health carrier shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. If the provider or a covered person will not release necessary information, the health carrier may deny certification.

Section 22. In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures. A health carrier shall include

a summary of its utilization review procedures in materials intended for prospective covered persons. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

Section 23. Nothing in this Act applies to dental only, vision only, accident only, school accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.

Section 24. If the director of the Division of Insurance and the secretary of the Department of Health find that the requirements of any private accrediting body meet the requirements of utilization review as set forth in this Act, the health carrier may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 25. The director may, after consultation with the secretary of the Department of Health, promulgate rules pursuant to chapter 1-26 to carry out the provisions of the Act. The rules shall be designed to afford the public timely administration of utilization review and to assure that utilization review decisions are made in a fair and clinically acceptable manner. The rules may include the following:

(1) Definition of terms;

(2) Timing, form, and content of reports;

(3) Application of clinical criteria as it relates to utilization review;

(4) Written determinations; and

(5) Utilization review procedures.

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I certify that the attached Act originated in the

HOUSE as Bill No. 1012

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Chief Clerk

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_____
Speaker of the House

Attest:

_____
Chief Clerk

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President of the Senate

Attest:

_____
Secretary of the Senate

House Bill No. 1012
File No. ____
Chapter No. _____

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Received at this Executive Office this ____ day of _____ ,

19___ at _____ M.

By _____
for the Governor

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The attached Act is hereby approved this _____ day of _____ , A.D., 19___

_____
Governor

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STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____ , 19___ at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State